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SENATE BILL 3328
By Kilby

AN ACT to amend Tennessee Code Annotated, Title 56, relative to expanding health care access and reduce costs through the creation of small business health plans.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. This act may be cited as the "Tennessee Health Insurance for Small Business and Affordability Act of 2006".

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 26, is amended by adding the following as a new part:

Section 56-26-501.

(a) For purposes of this part, the term:

(1) "Affiliated member" means, in connection with a sponsor:

(A) A person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor;

(B) In the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor; or

(C) In the case of a small business health plan in existence on the effective date of this act, a person eligible to be a member of the sponsor or one of its member associations.

(2) "Commissioner" means the commissioner of commerce and insurance.

(3) “Department” means the department of commerce and insurance.

(4) "Eligible insurer" means a health insurance issuer that is licensed in this state and that:

(A) Notifies the department not later than thirty (30) days prior to the offering of coverage, that the issuer intends to offer group health insurance coverage consistent with the benefit compendium, and provides with such notice a copy of any insurance policy that the insurer intends to offer in this state, its most recent annual and quarterly financial reports, and any other information required to be filed with the department of the state by the commissioner in regulations; and

(B) Includes in the terms of the health insurance coverage offered in this state (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the department pursuant to subdivision (A), a description in the insurer's contract of the benefit compendium and that adherence to the compendium is included as a term of such contract.

(5) "Group health plan" has the meaning provided in § 56-7-2802.

(6) "Health insurance coverage" has the meaning provided in § 56-7-2802.

(7) "Health insurance issuer" has the meaning provided in § 56-7-2802.

(8)

(A) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B)

(i) Subject to subdivision (ii), such term includes coverage offered in connection with a group health plan that has fewer than two (2) participants as current employees or participants on the first day of the plan year.

(ii) Subdivision (i) shall not apply in the case of health insurance coverage offered in the state if the department regulates the coverage described in subdivision (i) in the same manner and to the same extent as coverage in the small group market is regulated by the state.

(9) "Medical care" has the meaning provided as established by rule by the commissioner.

(10) "Participating employer" means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

(11) "Small employer" means, in connection with a group health plan with respect to a plan year, a small employer as defined in § 56-7-2802.

(b) For purposes of determining whether a plan, fund, or program is a small business health plan, and for purposes of applying this part in connection with such plan, fund, or program so determined to be a small business health plan:

(1) In the case of a partnership, the term "employer" includes the partnership in relation to the partners, and the term "employee" includes any partner in relation to the partnership; and

(2) In the case of a self-employed individual, the term "employer" and the term "employee" shall include such individual.

Section 56-26-502.

(a) For purposes of this part, "small business health plan" means a fully insured group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

(b) The sponsor of a group health plan is described in this subsection if such sponsor:

(1) Is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of § 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

(2) Is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

(3) Does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of subdivisions (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

Section 56-26-503.

(a) Not later than six (6) months after the effective date of this part, the commissioner shall prescribe by rule a procedure under which the commissioner shall certify small business health plans which apply for certification as meeting the requirements of this part.

(b) A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

(c) The commissioner may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small employer health plan involved is failing to comply with the requirements of this part.

(d) The commissioner shall establish a class certification procedure for small business health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such small business health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under § 56-26-507(a).

Section 56-26-504.

(a) The requirements of this subsection are met with respect to a small business health plan if the sponsor has met (or is deemed under this part to have met) the requirements of § 56-26-502(b) for a continuous period of not less than three (3) years ending with the date of the application for certification under this part.

(b) The requirements of this subsection are met with respect to a small business health plan if the following requirements are met:

(1) The plan is operated, pursuant to a plan document, by a board of trustees which pursuant to a trust agreement has complete fiscal control over the plan and which is responsible for all operations of the plan.

(2) The board of trustees has in effect rules of operation and financial controls, based on a three (3) year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

(3)

(A)

(i) Except as provided in subdivisons (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

(ii)

(*a*) Except as provided in subdivisions (*b*) and (*c*), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

(*b*) Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than twenty-five percent (25%) of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

(*c*) In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subdivision (3)(A)(ii)(*a*) shall not apply in the case of any service provider described in such subdivision who is a provider of medical care under the plan.

(iii) Subdivision (i) shall not apply to a small business health plan which is in existence on the effective date of this act.

(B) The board has sole authority under the plan to approve applications for participation in the plan and to contract with insurers and service providers.

(c) In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees:

(1) The requirements of subsection (a) and § 56-26-502(a) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in § 56-26-502(b), such network were deemed to be an association described in § 56-26-502(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in § 56-26-502(b); and

(2) The requirements of § 56-26-505(a)(1) shall be deemed met.

The commissioner may by regulation define for purposes of this subsection the terms "franchiser", "franchise network", and "franchisee".

Section 56-26-505.

(a) The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan:

(1) Each participating employer must be:

(A) A member of the sponsor;

(B) The sponsor; or

(C) An affiliated member of the sponsor with respect to which the requirements of subsection (b) are met, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one (1) of the officers, directors, or employees of an employer, or at least one (1) of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

(2) All individuals commencing coverage under the plan after certification under this part must be:

(A) Active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

(B) The beneficiaries of individuals described in subdivision (A).

(b) In the case of a small business health plan in existence on the effective date of this act, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if:

(1) The affiliated member was an affiliated member on the date of certification under this part; or

(2) During the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such small business health plan.

(c) The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

(d) The requirements of this subsection are met with respect to a small business health plan if:

(1) Under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in § 2711 of the federal Public Health Service Act, codified as § 42 USC 300gg -11, are not met; and

(2) Upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan.

Section 56-26-506.

(a) The requirements of this section are met with respect to a small business health plan if the following requirements are met:

(1)

(A) The instruments governing the plan include a written instrument, which:

(i) Provides that the board of directors serves as the named fiduciary and serves in the capacity of a plan administrator; and

(ii) Provides that the sponsor of the plan is to serve as plan sponsor.

(B) The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

(2)

(A) The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged.

(B) Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan, and at the request of such small business health plan, from:

(i) Setting contribution rates for the small business health plan based on the claims experience of the plan so long as any variation in such rates complies with the requirements of subdivision (ii); or

(ii) Varying contribution rates for participating employers in a small business health plan to the extent that such rates could vary using the same methodology employed for regulating premium rates, subject to the provisions of §§ 56-26-501, 56-26-509 and 56-26-510.

(3) Such other requirements as the commissioner determines are necessary to carry out the purposes of this part, which shall be prescribed by regulation.

(b) Nothing in this part or any provision of this title shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan, from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of §§ 56-26-501, 56-26-509 and 56-26-510.

Section 56-26-507.

(a) Under the procedure prescribed pursuant to § 56-26-503(a), a small business health plan shall pay to the department at the time of filing an application for certification under this part a filing fee in the amount of five thousand dollars ($5,000), which shall be available to the extent provided in the general appropriation act, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

(b) An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the commissioner by regulation, at least the following information:

(1) The names and addresses of:

(A) The sponsor; and

(B) The members of the board of trustees of the plan.

(2) The counties in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such county.

(3) Evidence provided by the board of trustees that any bonding requirements will be met as of the date of the application or (if later) commencement of operations.

(4) A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

(5) A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

(c) A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the department.

(d) In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the commissioner by regulation. The commissioner may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification. Section 56-26-508.

(a) A small business health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees not less than sixty (60) days before the proposed termination date:

(1) Provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

(2) Develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

(3) Submits such plan in writing to the commissioner.

(b) Actions required under this section shall be taken in such form and manner as may be prescribed by the commissioner by regulation.

Section 56-26-509.

(a) Not later than three (3) months after the effective date of this act, the commissioner shall issue by rule a list (to be known as the "list of required benefits") of the benefit, service, and provider mandates that the commissioner determines to be required to be provided by health insurance issuers in this state and in at least forty-five (45) other states as a result of the application of state benefit, service, and provider mandate laws.

(b)

(1) Not later than twelve (12) months after the effective date of this act, the commissioner shall issue by rule a compendium (to be known as the "benefit compendium") of the benefit, service, and provider mandates identified under subsection (a) that the commissioner determines shall be required under this part. In developing the compendium, with respect to differences in state

mandate laws identified under subsection (a) relating to similar benefits, services, or providers, the commissioner shall review the scope and application of such state laws. In making such determination, the commissioner shall strive to adopt an approach reflective of the approach used by a plurality of the states requiring such benefit, service, or provider mandate.

(2) The benefit compendium shall provide that any state benefit, service, and provider mandate law (enacted prior to or after the effective date of this act unless the enacting legislation provides otherwise) other than those described in the compendium shall not be binding on health insurance issuers in this state operating under this part.

(3) The effective date of the benefit compendium shall be the later of:

(A) The date that is twelve (12) months from the effective date of this act; or

(B) Such subsequent date on which the rule for the benefit compendium shall take effect.

(c) With respect to health insurers selling insurance to small employers, in the event the commissioner fails to issue the benefit compendium within twelve (12) months of the effective date of this act, the required scope and application for each benefit or service listed in the list of required benefits shall, other than with respect to insurance issued to a small business health plan, be that otherwise required by the provisions of this act.

(d) Not later than two (2) years after the date on which the compendium is issued under subsection (b)(1), and every two (2) years thereafter, the commissioner, applying the same methodology provided for in subsections (a) and (b)(1), in consultation with the National Association of Insurance Commissioners, shall update the compendium. The

commissioner shall issue the updated compendium by regulation, and such updated compendium shall be effective upon the first plan year following the issuance of such regulation.

Section 56-26-510.

(a) This part shall supersede any and all provisions of title 56 insofar as such laws:

(1) Prohibit an eligible insurer from offering coverage consistent with the benefit compendium in this state; or

(2) Discriminate against or among eligible insurers offering or seeking to offer health insurance coverage consistent with the benefit compendium in this state.

(b) Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers under this part who offer health insurance coverage in this state.

SECTION 3. The commissioner is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 4. The provisions of this act shall not be construed to be an appropriation of funds and no funds shall be obligated or expended pursuant to this act unless such funds are specifically appropriated by the general appropriations act.

SECTION 5. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 6. This act shall take effect on becoming law for the purpose of rulemaking, and for all other purposes it shall take effect on January 1, 2007, the public welfare requiring it.